Northfield Hospital
Northfield Hospital and Clinics

PEDIATRIC PATIENT INFORMATION
(Under 6 months)

FamilyHealth
FamilyHealth Medical Clinic

PATIENT INFORMATION

Name: ______________________ Date of birth: ______________

Phone number: ______________

Allergies: ______________________________

Parent/Guardian Name: ______________ Occupation: ______________

Relationship to patient: ______________

Parent/Guardian Name: ______________ Occupation: ______________

Relationship to patient: ______________

Is child adopted? ❑ Yes ❑ No

Interpreter needed? ❑ Yes ❑ No ______________

PAST MEDICAL HISTORY

Prenatal History

Mode of delivery: ❑ Vaginal ❑ Primary C/S-Labored ❑ Vacuum ❑ Primary C/S-No labor ❑ Forceps ❑ Repeat C/S

Birth weight: ______________ Gestation: ______________

Complications with Pregnancy/Delivery: ______________

Newborn Metabolic Screen results: ❑ Normal ❑ Abnormal

Hearing Screen results: ❑ Pass ❑ Fail Date of hearing re-screen pass: __________ ❑ Referred: __________

Medical History

None	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Premature birth	❑ Yes	❑ No	Recurrent ear infections	❑ Yes	❑ No
R.S.V.	❑ Yes	❑ No	Drug-resistant organisms (MRSA/VRE)	❑ Yes	❑ No
Bronchiolitis	❑ Yes	❑ No	HIV / AIDS	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Eczema	❑ Yes	❑ No
Heart defects/heart disease	❑ Yes	❑ No	Dental concerns	❑ Yes	❑ No

Other health problems? ❑ Yes ❑ No ______________

Hospitalizations? ❑ Yes ❑ No ______________

Are immunizations on schedule? ❑ Yes ❑ No ______________

Previous reaction to immunizations? ❑ Yes ❑ No ______________

SURGICAL HISTORY

None? ❑ Yes ❑ No ______________

Appendectomy? ❑ Yes ❑ No ______________

Tonsillectomy? ❑ Yes ❑ No ______________

Adenoidectomy? ❑ Yes ❑ No ______________

Ear tube placement? ❑ Yes ❑ No ______________

Other previous surgical procedures? ❑ Yes ❑ No ______________

(continued, over…)

FAMILY HISTORY

Condition		Relation	Age Diagnosed
Unknown?	❑ Yes ❑ No	______	______
Aneurysms?	❑ Yes ❑ No	______	______
Asthma?	❑ Yes ❑ No	______	______
Bleeding tendencies?	❑ Yes ❑ No	______	______
Stroke?	❑ Yes ❑ No	______	______
Pulmonary embolism?	❑ Yes ❑ No	______	______
Heart problems?	❑ Yes ❑ No	______	______
High cholesterol?	❑ Yes ❑ No	______	______
High blood pressure?	❑ Yes ❑ No	______	______
Seizures?	❑ Yes ❑ No	______	______
Cancer?	❑ Yes ❑ No	______	______
Diabetes?	❑ Yes ❑ No	______	______
Mental Illness?	❑ Yes ❑ No	______	______
Sudden infant death syndrome?	❑ Yes ❑ No	______	______
Birth defects?	❑ Yes ❑ No	______	______
Genetic condition?	❑ Yes ❑ No	______	______
Drug abuse?	❑ Yes ❑ No	______	______
Alcohol dependency?	❑ Yes ❑ No	______	______
HIV/AIDS?	❑ Yes ❑ No	______	______
Thyroid disease?	❑ Yes ❑ No	______	______
Tuberculosis?	❑ Yes ❑ No	______	______
Other health problems?	❑ Yes ❑ No	______	______

Is child's father deceased? ❑ Yes ❑ No Cause of death: ______ Age: ______

Is child's mother deceased? ❑ Yes ❑ No Cause of death: ______ Age: ______

SOCIAL HISTORY

With whom does the child live? ______ Total number of siblings: ______

	Sibling's name	Relationship to patient	Birth date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(continued…)

SOCIAL HISTORY *(continued)*

Day care provider: ❑ Home day care ❑ Day care provider ❑ Relative or friend ❑ None

Religious or cultural practices we need to know to better serve child's needs?... ❑ Yes ❑ No

HEALTH RISK PROFILE

Latex Allergy Risk:

Allergy to latex? ....❑ Yes ❑ No ______________________________

Reaction to medical procedure? ....❑ Yes ❑ No ______________________________

Exposure to secondhand smoke? ❑ No ❑ Yes (If "yes," who and where?: ______________________)

Pediatric Health Risk Prevention:

Bike helmet use? ....❑ Yes ❑ No ______________________________

Car seat/booster seat use? ....❑ Yes ❑ No ______________________________

Seatbelt use? ....❑ Yes ❑ No ______________________________

Smoke detectors in home? ....❑ Yes ❑ No ______________________________

Carbon monoxide detectors in home? ..❑ Yes ❑ No ______________________________

Pediatric Health Risk Hazards:

Lead exposure?.................................. ❑ Yes ❑ No ______________________________

Guns in home? .... ❑ Yes ❑ No ______________________________

Domestic violence?............................. ❑ Yes ❑ No ______________________________

Alcohol use in home? .... ❑ Yes ❑ No ______________________________

Drug use in home? .... ❑ Yes ❑ No ______________________________

Dental visit during past year? .... ❑ Yes ❑ No ______________________________